PRINTED: 7/19/2023 FORM APPROVED 2567-L

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395974		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/06/2023	
NAME OF PROVIDER OR SUPPLIER: MONTICELLO HOUSE STATE LICENSE NUMBER: 017302			STREET ADDRESS, CITY, STATE, ZIP CODE: 1048 WEST BALTIMORE PIKE MEDIA, PA 19063				
(X4) ID PREFIX TAG	SUMMARY STATEMEN MUST BE PRECEED IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE	
F 0000	Findings of an Abbreviated Complaint Surcompleted on April 6, 2023 at Monticello I identified no deficient practice, related to the reported complaint allegations, under the requirements of 42 CFR Part 483, Subpart Requirements for Long Term Care Facilitie 28 PA Code, Commonwealth of Pennsylva Term Care Licensure Regulations as they rethe Health portion of the survey process.		House he B es and the unia Long	F 0000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:							

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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Certified End Page

MONTICELLO HOUSE

STATE LICENSE NUMBER: 017302 SURVEY EXIT DATE: 04/06/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY